Vermont Department of Mental Health Quick Facts
February 2012

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

By statute, DMH is mandated to:

- Coordinate efforts of all agencies and services, government or private, on a statewide basis in order to promote and improve the mental health of Vermonters through outreach, education and other activities
- Integrate and coordinate mental health programs and services with other programs and services provided to ensure a flexible comprehensive service to all citizens of the state
- Operate the Vermont State Hospital

The total DMH proposed budget is $174 million, of which $166 million is funded by Medicaid through the Global Commitment, (56% of that, or $93 million, is federally funded).

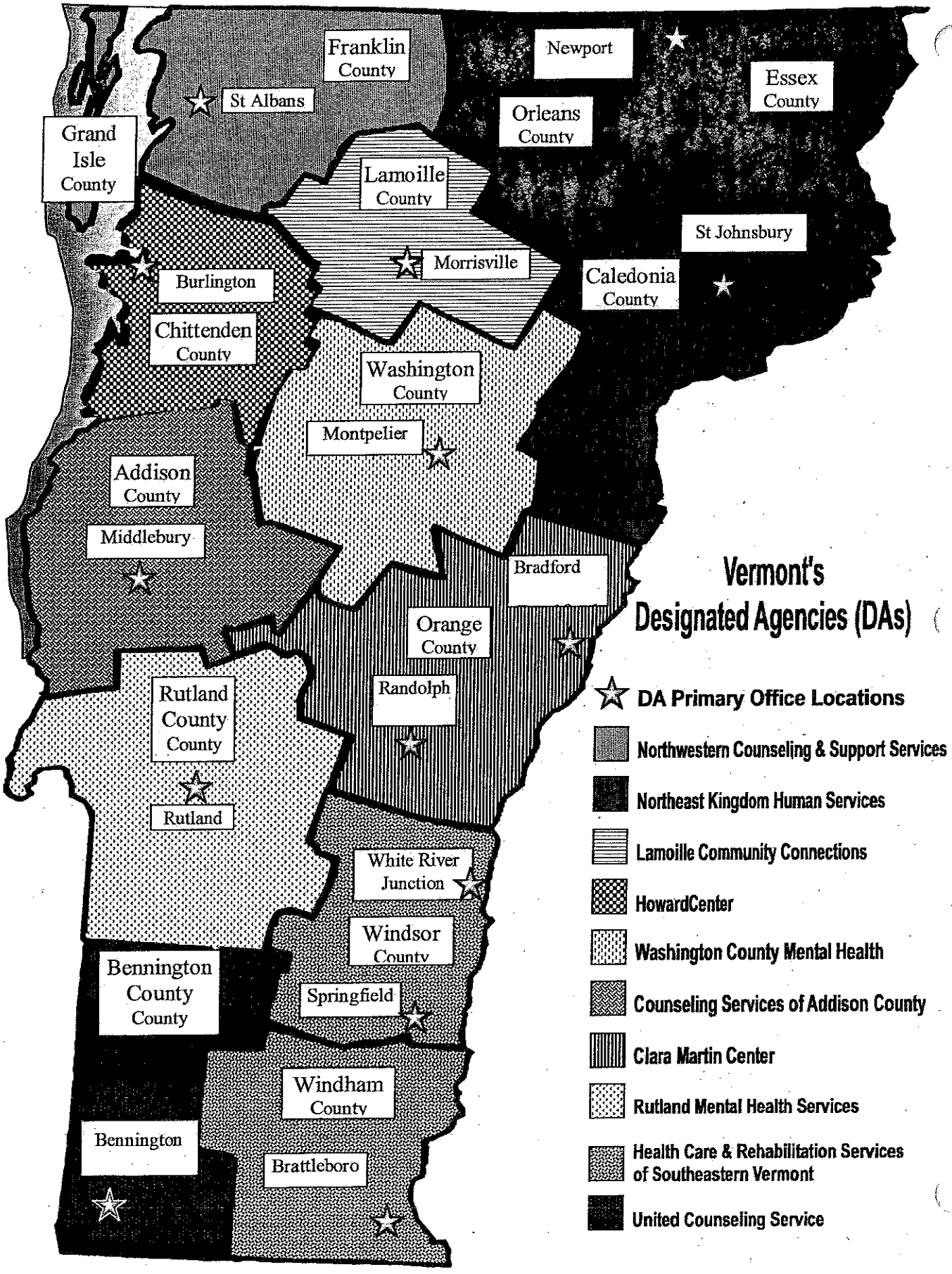
DMH contracts with and formally designates 11 community mental health care providers (often called Designated Agencies (DAs) or Specialized Services Agencies) for the provision of mental health services.

- DAs are located throughout the state and are responsible for serving a specified geographic area.
- DAs are required to serve adults with severe and persistent mental illness and children with serious emotional disturbance.
- DAs employ nearly 2,000 full time equivalent staff and serve over 26,000 Vermonters annually.

DMH has designated five community hospitals to provide involuntary psychiatric inpatient treatment to adults. The Brattleboro Retreat is the only designated hospital that serves children.

DMH operated the Vermont State Hospital. The Vermont State Hospital was Vermont's most intensive and restrictive psychiatric inpatient program.

DMH collects, coordinates and analyzes clinical and financial data pertaining to the mental health system. This data collection and analysis is continually used to improve the quality and cost effectiveness of the mental health delivery system.


Franklin County
St Albans
Grand Isle County
Newport
Essex County
Orleans County
Lamoille County
Morrisville
St Johnsbury
Caledonia County
Burlington
Chittenden County
Washington County
Montpelier
Addison County
Middlebury
Bradford
Orange County
Randolph
Rutland County County
Rutland
White River Junction
Windsor County
Bennington County County
Springfield
Windham County
Bennington
Brattleboro
Vermont's Designated Agencies (DAs)
DA Primary Office Locations
Northwestern Counseling & Support Services
Northeast Kingdom Human Services
Lamoille Community Connections
HowardCenter
Washington County Mental Health
Counseling Services of Addison County
Clara Martin Center
Rutland Mental Health Services
Health Care & Rehabilitation Services of Southeastern Vermont
United Counseling Service

Vermont Department of Mental Health

Fiscal Year 2013

Budget Request

February 4, 2012

Department of Mental Health

VISION

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to, the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

MISSION

It is the mission of the Vermont Department of Mental Health to promote and improve the mental health of Vermonters.

VALUES

We support and believe in the Agency of Human Services values of respect, integrity, and commitment to excellence and express these as:

Excellence in Customer Service

- People receiving mental health services and their families should be informed and involved in planning at the individual and the system levels
- Services must be accessible, of high quality and reflect state-of-the-art practices.
- A continuum of community-based services is the foundation of our system.

Holistic approach to our clients

- We can promote resilience and recovery through effective prevention, treatment, and support services.

Strength Based Relationships

- It is important to foster the strengths of individuals, families, and communities.

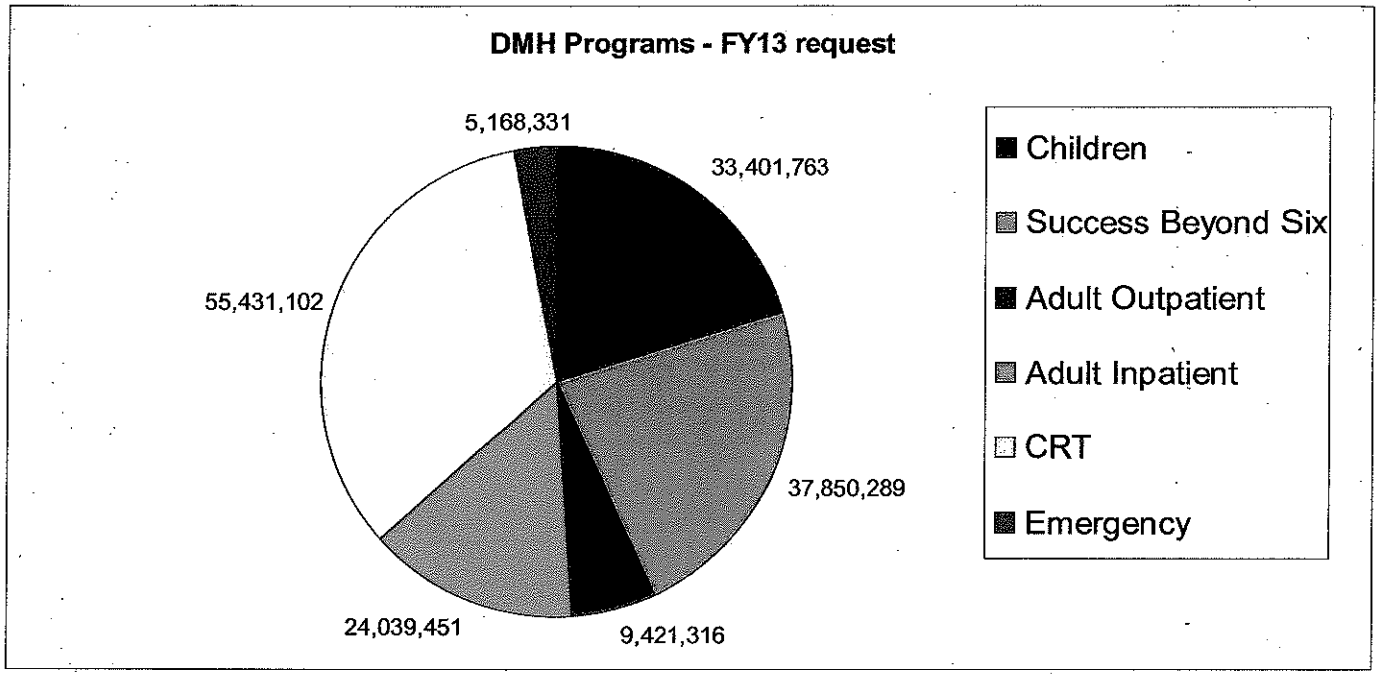
Results Orientation

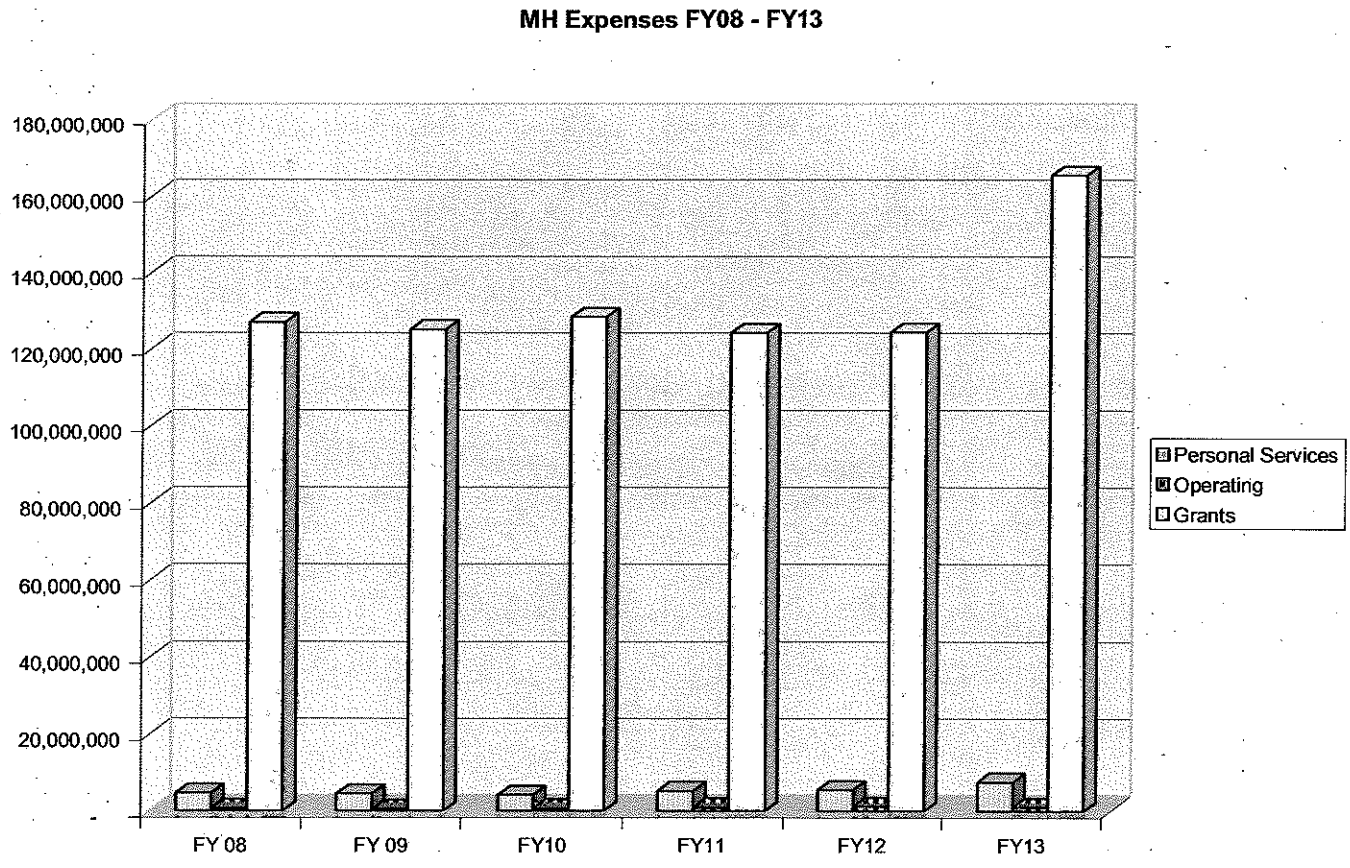
- Strong leadership, active partnerships and innovation are vital strategies to achieve our mission.
- We are accountable for results.

Priority Service Functions of DMH

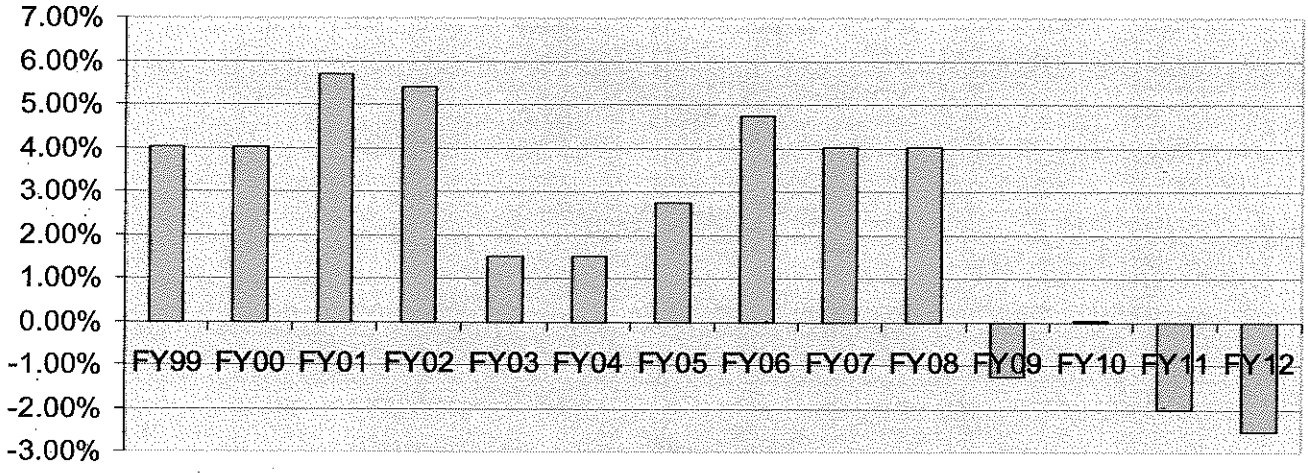
The Department of Mental Health (DMH) commitment to direct services and community-based mental health care and treatment is reflected in the following priority areas.

- Following Tropical Storm Irene and the closure of the Vermont State Hospital (VSH), the highest priority of the DMH is to ensure the provision of acute inpatient psychiatric care for persons who would otherwise have been hospitalized at the VSH.
- The Designated Agency (DA) community-based mental health service delivery system holds the second and third major priority functions of the DMH.
    - This system includes the Community Rehabilitation and Treatment (CRT) programs serving adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED).
    - The third DMH priority function is the Emergency Services Programs with a 24/7 mental health crisis response capacity at each DA.
- The final priority function of DMH is the operations of the central office for budget development, resource acquisition and allocation, and oversight of the system of mental health service delivery and care.

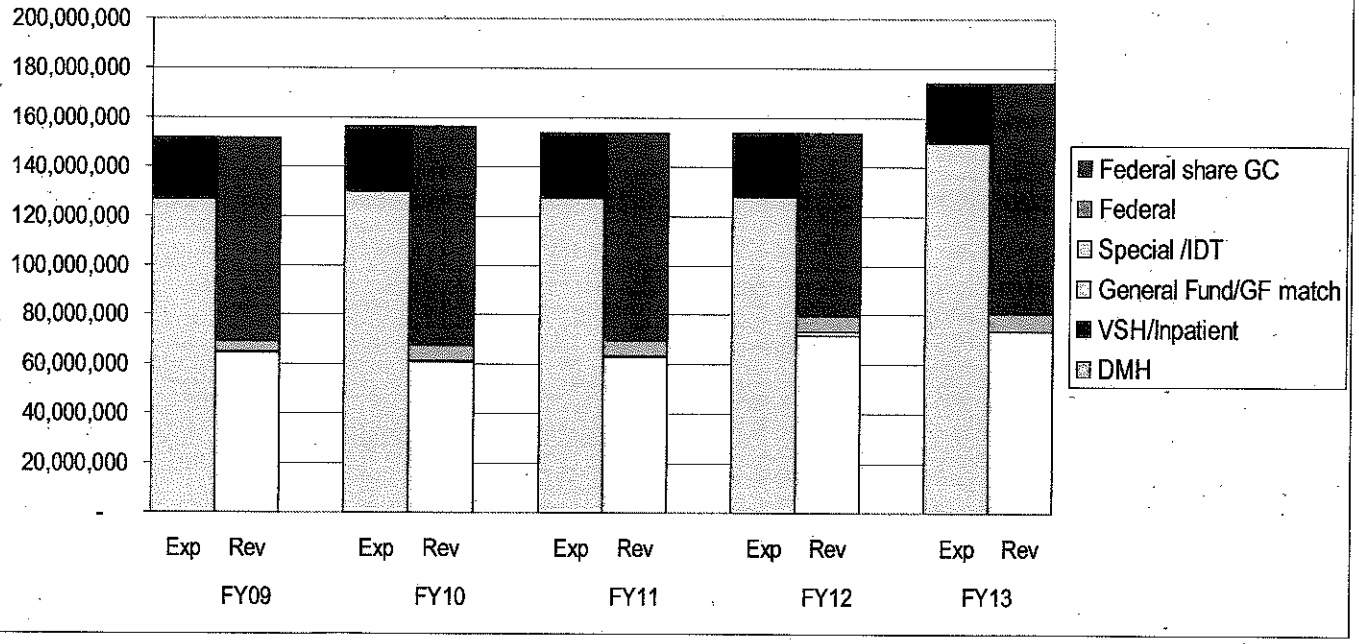

DMH Programs - FY13 request
5,168,331
33,401,763
55,431,102
37,850,289
24,039,451
9,421,316
Children
Success Beyond Six
Adult Outpatient
Adult Inpatient
CRT
Emergency


MH Expenses FY08 - FY13
180,000,000
160,000,000
140,000,000
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
-
FY 08
FY 09
FY10
FY11
FY12
FY13
Personal Services
Operating
Grants

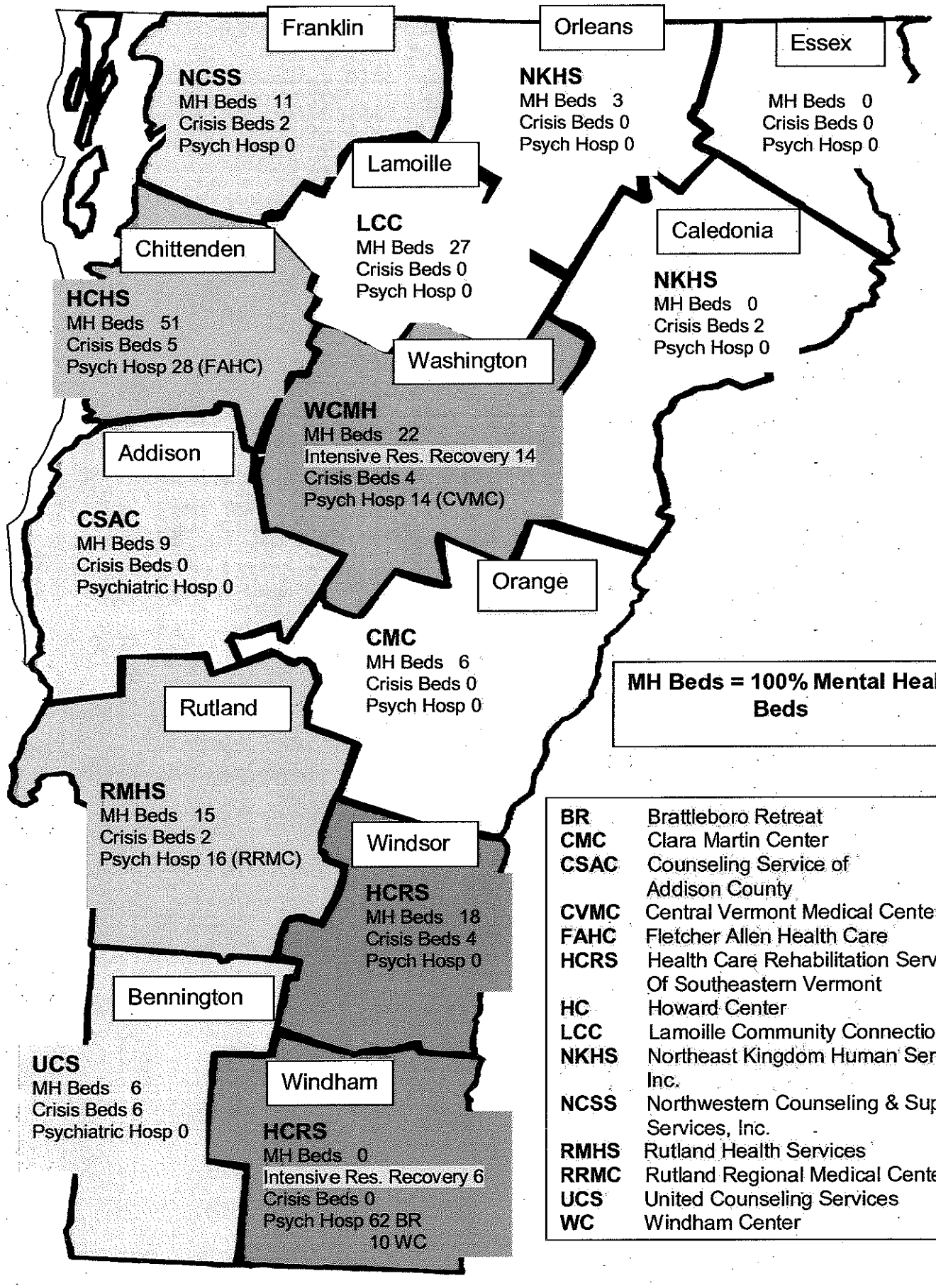
State Funded Designated Agency Inflationary Increases/Reductions FY 99 - FY 12



Department of Mental Health Revenue and Expenses



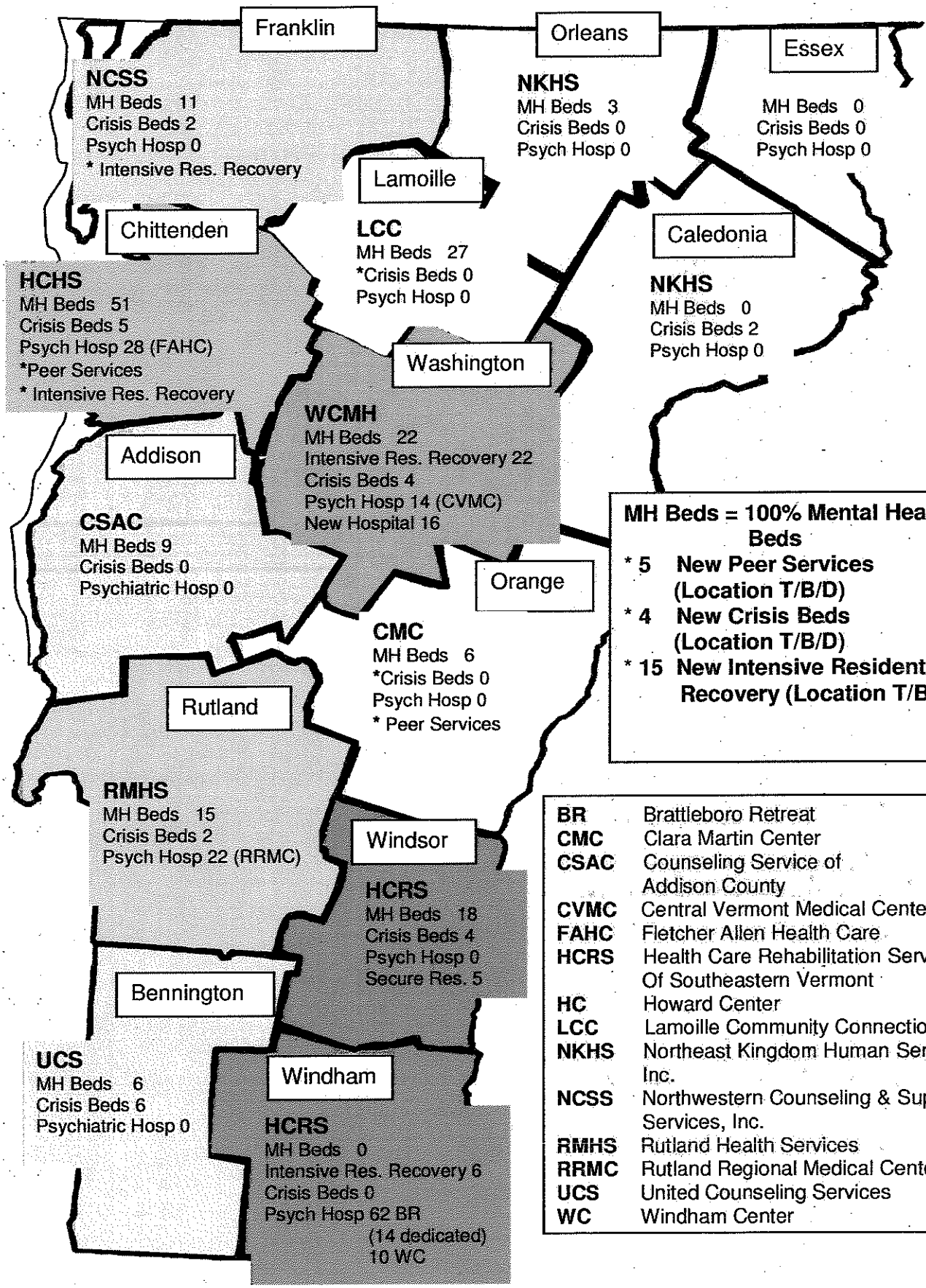
CURRENT MENTAL HEALTH SERVICES BY COUNTY



MH Beds = 100% Mental Health Beds

BR	Brattleboro Retreat
CMC	Clara Martin Center
CSAC	Counseling Service of Addison County
CVMC	Central Vermont Medical Center
FAHC	Fletcher Allen Health Care
HCRS	Health Care Rehabilitation Services Of Southeastern Vermont
HC	Howard Center
LCC	Lamoille Community Connections
NKHS	Northeast Kingdom Human Services, Inc.
NCSS	Northwestern Counseling & Support Services, Inc.
RMHS	Rutland Health Services
RRMC	Rutland Regional Medical Center
UCS	United Counseling Services
WC	Windham Center

PROPOSED MENTAL HEALTH SERVICES BY COUNTY



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About the Department of Mental Health – Pre Tropical Storm Irene

State law specifies that Vermont's publicly-funded community services system for individuals of all ages with mental health disorders be provided through contracts between the DMH and private, nonprofit community provider agencies. Currently, DMH contracts with 11 such provider agencies, ten of which are known as Designated Agencies (DA s) and one of which is a Specialized Service Agency (SSA). There is only one DA per geographic region. The DA's have, by statute, bottom line responsibility for assuring that a comprehensive range of services is available for the following priority populations within their defined service area: Adults with severe and persistent mental illness (SPMI) and children and adolescents with severe emotional disturbances (SED). The DMH also contracts with one SSA to provide services only for children and adolescents.

DEPARTMENT OPERATIONS AND PROVIDER MANAGEMENT

Operations

The central office of the Vermont Department of Mental Health ensures that internal and external program operations pursuant to its statutory responsibilities under 18 V.S.A. Chapter 173 are adequately resourced, monitored, and that development activities sustain and promote the existing public mental health adult and child services network. Operations functions include administrative support, financial services, legal services, provider monitoring, care management and utilization review, system development and technical assistance, and community housing.

The **Administrative Support Unit** staff are often the first point of contact and triage for incoming inquiries from consumers, family members, and service providers. Administrative Support Services staff respond to the daily internal and external communication flow with operations and clinical services staff, AHS and our community partners. Support staff work closely with program staff in the development and execution of service provider contracts and grants, as well as, ordering, production, document management, and other clerical services necessary to support their respective units within the DMH.

The **Financial Services Unit** works closely with all staff; internally overseeing the budget development process as well as invoicing, coding, accounting, and ensuring payment authorizations for sub-contractors and grantees while externally tracking and monitoring financial reporting and accountability of the DMH, the DA provider system and community-based advocacy, family, and consumer-run organizations.

The **Legal Services Unit** is comprised of staff from the Attorneys General Office and DMH paralegals. It supports the DMH with legislative and policy review activities, tracking individual court orders and petitions, and various other proceedings requiring attorney representation.

Provider Oversight/Performance Indicators

Central office staff members from both the Adult Unit and the Child and Family Unit (CAFU) are responsible for monitoring community program services, designating agencies every four years as outlined in the Administrative Rules for Agency Designation, and designation of hospitals for involuntary psychiatric care through various oversight activities of the DMH. Additionally, the DMH, under the statutory responsibilities of the Commissioner of Mental Health (18 V.S.A. § 7408), oversees Electroconvulsive Therapy (ECT) treatment. Staff members ensure that review activities for DA's and hospitals are conducted and corroborating program, policy, and outcomes information compiled. Research and Statistical Unit personnel provide routine and ad hoc data review and analysis from various provider services information and data submissions. The activities include agency reviews, records documentation minimum standards, and tracking agency or hospital information reporting for the ten DA's, one SSA, and the five Designated Hospital psychiatric inpatient programs.

Quarterly, key financial performance indicators are composed and reviewed for signs of fiscal weaknesses. In particular, days of net assets, current ratio, gain/loss, days of cash, and admin cost ratio are closely examined. Monthly financial data and client-level encounter data are submitted to DMH for purposes of tracking both financial health of the organization and service delivery to persons served by the DA. Any agency highlighted as having potential shortfalls is contacted and dealt with on an individual basis. Provider grant agreements are developed annually to outline service delivery level expectations.

Clinical Care Management and Utilization Review

Formerly, the review activities of this unit were guided by the State's Medicaid Global Commitment Waiver and Managed Care Organization (MCO) requirements and focused on the use on the use and authorization of inpatient care for adult clients with the most intensive mental health services needs Community Rehabilitation and Treatment (CRT) program clients and notification of persons subject to involuntary emergency examination hospitalization. Subsequent to the closure of the VSH, the care management team has needed to expand its support activities with the Designated Hospitals to facilitate diversion to clinically appropriate alternative care settings or timely transfer to community services from inpatient care.

Two staff members are directly responsible for acute CRT inpatient authorization and continued stay reviews with five Designated Hospitals (DH's). The remaining care coordinators have recently begun working directly with the DH's to address the needs of any person in the care and custody of the Commissioner of Mental Health with complex mental health needs or voluntary psychiatric inpatients who are experiencing barriers to community services and timely discharge. This team works closely with Emergency Services Programs to identify needed community services and alternative levels of care to respond to crises. This unit, in conjunction with legal services, provides training to the Qualified Mental Health Professionals who screen admissions into involuntary care and the custody of the Commissioner of Mental Health.

System Development and Technical Assistance

The DMH actively explores funding opportunities, as well as, community collaboration and mental health practice improvement initiatives. These efforts are designed to bring supplemental federal and other grant resources to our mental health provider system and assure that the work force is current with new treatment approaches and evidence-based practices in the field of community mental health services. In addition, the DMH staff provide consultation to program development initiatives and technical assistance for the implementation of specific practices.

Community Housing

Access to safe, affordable housing is critical to the well being of Vermonters with disabilities and who live on extremely limited incomes. The DMH assumes a leadership role in the development and preservation of, and access to affordable housing. Staff coordinates the continuation of existing HUD funding and actively pursues opportunities for new funding for housing. These activities require close working relationships with Vermont's not-for-profit housing developers and with the local and state housing authorities. In addition, DMH works closely with the shelters and service providers who assist Vermonters who are homeless to gain housing.

Vermont Department of Mental Health – Post Tropical Storm Irene for FY 13

Given the abrupt closure of the Vermont State Hospital due to flooding from Tropical Storm Irene, Vermont has the unique opportunity to reduce its reliance on institutional care and further build its community based system of care for persons with mental health conditions. The Department of Mental Health, consistent with the Shumlin Plan and newly available Medicaid and Medicare funding resources, has a unique opportunity to take significant steps forward in promoting a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care.

Services of the Vermont State Hospital that had been paid for only with state general funds can now be matched in large part with federal Medicaid and Medicare dollars. This change results in an additional $20 million that can be made available to support a more balanced and effective system of care in Vermont.

"This increase in federal funding allows us to expand and sustain critical community services such as residential programs for post hospital care, additional and flexible crisis and emergency supports, intensive wrap-around services for individuals, flexible out patient services, peer supports, and housing subsidies. We strongly believe that this combination of improved preventive services and step down capacity will have the impact of reducing hospital admissions and lengths of stay. "

Governor Peter Shumlin
Plan for Mental Health
January 9, 2012

Key components for further development:

- enhance and improve community services;
- integrate prevention and treatment services;
- develop robust peer services;
- enhance community hospitals;
- enhance department oversight and case management;
- develop a new state managed facility; and
- Improve outcomes for persons served.

➢ ENHANCED AND IMPROVED COMMUNITY SERVICES

Vermont's mental health care system has been working to provide evidence based and innovative practices to help people with recovery, to live independently, to work, and to fully participate in their communities. Funding constraints and eligibility criteria for more comprehensive services have limited service options. Only half of the admissions to the former VSH were for clients served in the most comprehensive services programs and experienced longer admissions if community programs were unable to meet their needs when ready for discharge. Likewise, individuals who were ineligible for state programs also experienced longer lengths of stay due to lack of appropriate or flexible community services and housing support options. In the coming fiscal year, DMH will work with the Designated Agencies (DA's) to:

Expand and Improve emergency, crisis, and residential supports - There is wide consensus that emergency services and support need to be more consistent, flexible and mobile. Services need to be able to respond to people in supportive ways, where they are, and be available 24/7 every day. Services need to integrate their work with local law enforcement, hospital emergency rooms and peer services where they exist. Alternative forms of transportation need to be available.

In addition, additional residential programs and crisis bed capacity, intended to prevent or divert hospitalization when appropriate, are needed. Additional crisis beds in areas lacking such resources will be developed in the upcoming year. These support programs will be immediately available to individuals in crisis who can be successfully served in an alternative treatment setting to hospitalization. Toward ongoing support and stabilization, new residential recovery facilities in the southern and northern-central portions of Vermont are in development as well. Proposals for locations and services have been received by DMH and are in the early stages of development and Certificate of Approval review. These facilities will serve people who no longer need acute in-patient care but are not yet ready for full independent living. These program environments will assist individuals in their recovery by providing a safe and secure setting and therapeutic services aimed at returning persons served to their communities.

Flexible Outpatient Services - Develop a stronger out patient service in the DA's, with a strong emphasis on identifying and responding to people at risk. Services must be flexible and person-centered to respond to the real needs and choices of the individuals. There must be case management to meet the needs of people who do not meet other eligibility criteria.

DMH will work closely with DVHA and the Blueprint for Health to more specifically identify high cost Medicaid beneficiaries with mental illnesses who are not currently served by other intensive programs. Likely investment areas include flexible case management services, integrated mental health and primary care services, and increasing the availability of health care services in the DA network.

Housing Subsidies - Research has shown that stable housing is one of the most important elements in preventing crisis and in supporting recovery. Yet, persons with mental health conditions often find themselves struggling to maintain stable housing and even worse, are at high risk for homelessness. DMH proposes to use allocated funds in the upcoming fiscal year to establish housing subsidies to ensure stable housing. Housing assistance should be provided as much as possible in the "housing first" model, in which housing is provided without pre-qualification or agreements to accept certain services in order to receive assistance. However, when desired, DMH though its DA network will deploy services from minimal case management to full wrap-around plans to keep the individual successfully housed.

➢ INTEGRATED PREVENTION AND TREATMENT SERVICES

Health Care Reform and the Blueprint - The State's Health Care Reform Plan includes integration of physical and mental health where all individuals have access to and insurance coverage for the services they need and costs increases are controlled. Any changes or new developments in providing mental health services must be integrated with these health care reform efforts, which include as a foundational element the Blueprint for Health. The Blueprint has already implemented an integrated advanced primary care medical home model for more than half of the state's population and can offer great promise for integrating traditional primary care and mental health and substance abuse treatment at the community level. DMH plans to monitor and more actively participate in further development of this model to assure that key mental health components are imbedded in these health care reform efforts.

Health care reform also includes plans for payment reform, moving away from fee-for-service payment and toward value-based payment systems. Particularly important to DMH are potential models of care and cost management for people who are dually-eligible for Medicare and Medicaid. A large percentage of persons served who may require ongoing services fall within this group, so developments in mental health for dually eligible persons must be congruent with other changes in the designated

agency delivery system. People with mental health conditions and providers must be fully engaged in health care reform.

Law enforcement and Department of Corrections - Individuals whose behaviors or problems might be better addressed through mental health services need to have access to assessment and services where indicated. New or expanded services must be developed with law enforcement involved from the start to ensure that those services are integrated. This enhanced teamwork will reduce negative interactions between law enforcement and people with mental health conditions.

In the upcoming fiscal year, DMH is establishing a team to focus on working with people involved with the criminal justice system. Over the past two years, positive work has been accomplished, helping individuals identified in Corrections as "SFI" (seriously functionally impaired) return to the community with support services. The Department team will continue to focus its efforts on ensuring quicker and more effective support services and release and preventing incarceration when possible and appropriate.

Substance Abuse - Individuals with substance dependence often have co-occurring mental health conditions and may have increased risk of involvement in the criminal justice system. DMH and the Alcohol and Substance Abuse Programs (ADAP) continue to work together to develop stronger, integrated systems of care. An emerging proposal from Blueprint for Health/DVHA to address specialized co-occurring substance abuse and mental health treatment in a more integrated manner is the development of a limited number of these centralized specialty treatment resources (Hubs) in the Blueprint Community Health Teams. These mental health and substance abuse professionals in the Hubs will be available to support primary care and specialty physicians (Spokes) in coordinating access to treatment and recovery supports. DMH applauds these efforts and plans to work collaboratively with these state programs to include mental health resources where needed in this initiative.

➢ GROWING PEER SERVICES

A peer is someone who has lived experience with a mental health condition and mental health services, in particular experience with involuntary hospitalization and medication. This lived experience brings unique perspective to working with other people experiencing a mental health condition or crisis. Vermont is extremely fortunate to have a capable but still small set of peer services. In keeping with its longstanding commitment to stakeholder inclusion in the development of new services, DMH established a peer services workgroup with a task of recommending growth and development of peer support. In the upcoming fiscal year with additional funding allocation as appropriated, DMH will continue its work with peers to implement recommendations put forward:

- Add funding to existing peer services organizations to expand their capacity and strengthen their organizations;
- Fund a state wide "warm line" run by peers to provide support and help people obtain services they need and choose;
- Develop a coordinating entity, preferably within an existing organization, to coordinate peer efforts at training, organizing, transportation alternatives and other activities; and
- Add funding for new peer services

➢ ENHANCED COMMUNITY HOSPITAL BEDS

Access to acute, in-patient care is a critical part of the system. Individuals needing inpatient mental health care should not be sitting in emergency rooms for many hours or even days awaiting a hospital admission. DMH believes that it can achieve the right balance of essential inpatient beds. The Vermont State Hospital was licensed for 54 beds. The night of the flood there were 52 patients at the facility, but

only about half actually needed acute inpatient care. At any given time approximately 25-30 individuals at VSH could have been effectively served in other treatment environments.

The current DMH plan seeks to create 36 inpatient beds to serve individuals who would otherwise have been treated at VSH. This plan anticipate long term agreements with two hospitals to provide more than half of these beds: the Brattleboro Retreat (14 beds) and Rutland Regional Medical Center (6 beds). In addition, DMH plans to develop a new state managed facility of 16 beds (but designed to be expanded to 25 if needed). During this period of renovations at Rutland Regional Medical Center and the Brattleboro Retreat, DMH will also contract with Fletcher Allen Health Care for 7-12 beds for acute in-patient care until the new state hospital is built.

Furthermore, the Department is investigating the possibility of creating additional temporary state hospital bed capacity in a former nursing home. If this temporary hospital can be licensed and certified for up to 20 beds, including the 5 beds planned for the Secure Residential facility, it will take great pressure off the hospital system until the new state hospital is built. Throughout this process, the existing psychiatric inpatient service capacity provided by Fletcher-Allen Health Care, Central Vermont Medical Center, and the Windham Center will remain part of the ongoing continuum of inpatient care service options. This geographic distribution of acute inpatient services will provide individuals with in-patient options closer to home which can be very important to their recovery and discharge planning needs.

DMH is actively planning with the Rutland and Brattleboro facilities to estimate renovations costs necessary to provide higher acuity services during this period of decreased inpatient bed capacity. The Brattleboro Retreat renovations are likely to be approximately $4 million and RRMC's renovations will likely be approximately $6 million. Given that these renovations are coming about in direct response to immediate service needs and the loss of VSH, DMH and the state expect that FEMA will cover the costs of these renovations. A Certificate of Need will be required for both projects with renovation commencing with CON and legislative approval. DMH is requesting an Emergency Certificate of Need to replace the state hospital, with the hospitals as co-applicants.

Long term agreements with the hospitals will include provisions for a "no-reject" system, reimbursement based on acuity and enhanced programming/staffing, and access to peer supports. One favorable element is that in these settings, care can be covered in part by Medicare, and even more so by Medicaid. This will result in a significant savings to the state general fund, even while services are expanded.

➢ DEPARTMENT OVERSIGHT AND CARE MANAGEMENT

Oversight - Given the changes in how services are provided for inpatient psychiatric services and both the investment and infusion of resources planned for enhance community-based services, the Department of Mental Health oversight and accountability for the quality of treatment and services is greatly intensified. Existing staff numbers at DMH are unable to absorb additional oversight, analysis, and reporting requirements necessary to demonstrate effective system oversight. DMH needs to expand staffing to meet the challenge of developing, implementing and monitoring the new system of services. All efforts will include utilizing VSH staff where possible to fill these positions.

DMH needs to increase its care management personnel to serve all regions of the state managing the flow of higher acuity and challenging to serve individuals. While inpatient, care coordinators will be essential in facilitating communication between inpatient and outpatient treatment providers, coordinating timely aftercare, and addressing barriers in accessing services in the community. While outpatient, care coordinators will monitor individuals who are at risk of psychiatrically decompensating,

coming to the attention of law enforcement or facing incarceration without support services, or on Orders of Non-hospitalization (ONH).

DMH plans to provide higher levels of technical assistance to hospitals and community services with behavior plan consultation and development and in furthering evidence-based practices and staff competencies where needed. Additionally, DMH will restore personnel for managing quality assurance oversight and developing performance improvement strategies for both inpatient and community services.

DMH also needs to grow its capacity to promote peer inclusion in its own infrastructure and promote lines of communication through dedicated ombudsman support services. Consistent with greater inclusion in health care reform, DMH also needs personnel who can focus on insuring cohesive system planning, development, and financial sustainability. Capacity for exploring funding and grant opportunities and workforce development are key long term strategies for overall system stability as well.

A core component of system oversight is stakeholder inclusion. Formally, DMH has access to State Program Standing Committees (representative bodies appointed by the Governor of persons served, family members, and provider organizations whose composition must be 51% persons served and family members) and the Transformation Council, a defined composition of state and community stakeholders, established to provide guidance to the Commissioner of DMH for system planning efforts. Additionally, DMH has created specific, time-limited workgroups open to any interested stakeholders and focusing on:

- New service proposals;
- Emergency Services;
- Warmline Development;
- Peer Services;
- Transportation;
- Housing; and
- Suicide Prevention.

The work of these groups is in varying stages of development and/or offering recommendations to DMH. It is anticipated that these workgroups will conclude their work in upcoming months. Recommendations put forward will be carried into FY 13.

Care Management System – DMH is developing a stronger clinical resource and oversight management system to supplement its earlier acute care management system specifically for individuals enrolled in its CRT Programs. The ultimate goal is to assure the highest quality care in the right place at the right time. The clinical resource management system will also ensure that people are not utilizing higher intensity services, particularly inpatient care or intensive residential services, when other less intensive services are more appropriate. Additionally, it will strengthen coordination among Agency of Human Services programs and systematically ensure that Vermont's mental health system is of the highest quality, fully integrated with the physical health care system and aligned with other state health care reform initiatives.

DMH has designated a specific group of employees, most of them former clinical staff from the Vermont State Hospital, as the clinical resource management team. The team includes social workers, nurses and psychiatrists. Additionally, the team receives support as needed from DMH Legal and Psychology.
After hours, the work of this group is complimented by the DMH (formerly VSH) Admissions Team that is responsive to incoming calls and coordinates the DMH response with 24/7 access to a

psychiatrist, a DMH leadership team member and a legal unit attorney to problem solve and ensure that a person gets the care needed. Sometimes this involves helping people come up with creative solutions identifying care needs and sometimes it involves authorizing additional funding for special cases.

This team is currently supported by the manual bed board, operated by DMH. The bed board is distributed twice a day, seven days a week. The bed board provides census information relating to the designated hospitals, the intensive recovery residential programs and the crisis beds. Soon, this will be replaced by an automated bed board where the data will be real time, not just twice a day. This census information will support the clinical resource management system, but is not a clinical resource management system. As it matures, this system will continue to have a dedicated team of clinical experts to provide both oversight and technical assistance support to the mental health system. In addition to the automated bed board, this team will likely draw from an electronic health record to ensure that all direct care providers will have coordinated clinical information (subject to appropriate privacy protections). Looking forward, the system will collect consistent data to inform quality improvement and care management activities. This data, consistent with current Blueprint activities, will measure outcomes and assess patient experience to ensure that the system is providing patient centered, highest quality, cost effective care that is continually improving. By working closely with DVHA, and particularly the Blueprint, DMH intends to leverage state resources supporting prevention and chronic care management to better serve all Vermonters with mental health needs.

➢ DEVELOPMENT OF A STATE RUN FACILITY

Governor Shumlin's plan includes a 16 bed state owned and operated hospital in Central Vermont. In conjunction with 14 beds at the Brattleboro Retreat and 6 beds at the Rutland Regional Medical Center, there will be 36 acute in-patient beds in the system when the new hospital is built. The plan is to construct this new hospital proximate to a medical center. This 16 bed facility will ensure that the state will not encounter a problem with the federal rule against Medicaid funding for Institutes for Mental Diseases. However, the Governor's plan also includes a plan to expand the 16 bed facility quickly to 25 if the demand and utilization demonstrates it is necessary.

➢ OUTCOMES

DMH anticipates that performance outcomes will be an essential component of determining system effectiveness in the wake of substantial access and service changes. Throughout FY 13, DMH plans to evaluate whether or not statutory changes may be needed to better ensure individual access. Throughout this process, DMH plans to actively solicit stakeholder involvement. Key measures will likely include A timely and full implementation of this plan will result in better outcomes for Vermonters with mental health conditions and include the following:

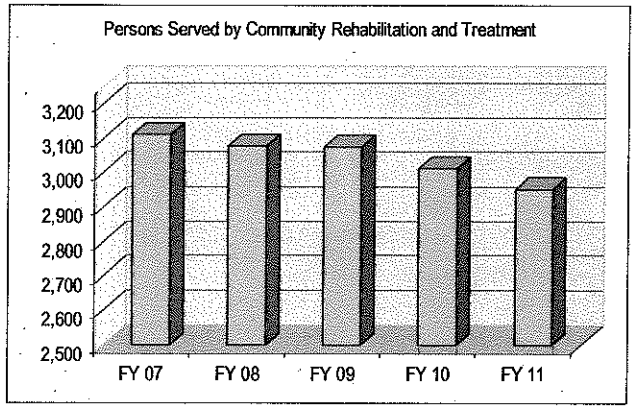
1. Reportable milestones of integration with Blueprint and Health Care Reform.
2. Reportable milestones on peer service development
3. Measures of individual access to care, services, and satisfaction.
4. Measures pertaining to law enforcement and DOC involvement
5. Measures pertaining to housing support and stability
6. Measures for employment
7. Measures of hospitalization and alternative service access

ADULT SERVICES

The Adult Services Unit of the Vermont DMH focuses on the public mental health system for Community Rehabilitation and Treatment (CRT), Adult Outpatient Services, Emergency Services, and inpatient hospitalizations at the designated hospitals in the community.

CRT Programs

Vermont is nationally recognized for using evidence-based practices to serve people with major mental illnesses. Evidence-based practices include supported employment, integrated treatment for mental illness and substance abuse, specialized treatment for people who are high users of services and will harm themselves, illness self-management and recovery, and family and peer-taught psycho-education for families and providers. CRT programs provide community-based mental health services to enable individuals to live with maximum independence in their communities among family, friends, and neighbors.



Over the past five years, the Designated Agencies have served an average of just over **3000** CRT clients per year. CRT clients are adults with severe and persistent mental illness who meet eligibility criteria that include diagnosis, service utilization and hospitalization history, severity of disability, and functional impairments.

Supported Employment for CRT Clients

Work is often cited as one of the most important components of recovery for people with mental illness. When people are working they are less likely to be using substances, involved in corrections, or utilizing in-patient services. Research shows they also benefit from better physical health, increased self-esteem, and access to social opportunities. The supported employment program helps CRT clients obtain and maintain competitive employment in their community. Evidence-based supported employment services are integrated within the overall mental health treatment in CRT and focus on consumer strengths, skills, and interests. In addition to providing employment supports to clients, supported employment specialists are well known to their community partners such as Vocational Rehabilitation, Vermont Association of Businesses, Industry, and Rehabilitation, the Department of Labor and Industry, Chambers of Commerce, Vermont Businesses for Social Responsibility, and local employers. Any CRT client who expresses the desire to work can receive employment services. For the past seven years, CRT clients with competitive employment in Vermont collectively earned nearly $35 million in taxable wages.

CRT Annual Employment and Average Wages Earned

Fiscal Year	Total # Served	Employed	Percent Employed	Total Wages	Average Wages
2007	2,971	803	27%	$5,130,765	$6,389
2008	2,928	768	26%	$5,065,598	$6,596
2009	2,850	678	24%	$4,321,767	$6,374
2010	2,736	550	20%	$3,618,664	$6,579
2011	2,756	516	19%	$3,311,628	$6,418

CRT Client Stability in the Community

The trend of CRT enrolled clients being admitted to VSH has remained extremely low with roughly only 3% of enrolled clients requiring VSH level of care on an annual basis. Roughly 97% of clients enrolled in the CRT Program receive their services in the community or at sites other than hospitals, showing that CRT services for seriously mentally ill individuals significantly decreases the need for the state's most restrictive

and highest cost level of psychiatric inpatient hospitalization. While the overall admission rate for CRT clients is low, the FY 10 utilization rate of VSH hospitalization for those individuals accounted for approximately 63% of the total admissions to VSH and in FY 11 accounted for 71% of the total hospital bed day utilization. So, while this is a relatively low number of individuals, their need for more structured and intensive treatment services, for longer periods of time, represents a disproportionate utilization of high end system resources.

Patient Bed Days of CRT Enrollees to Vermont State Hospital Fiscal Years 2007 - 2011

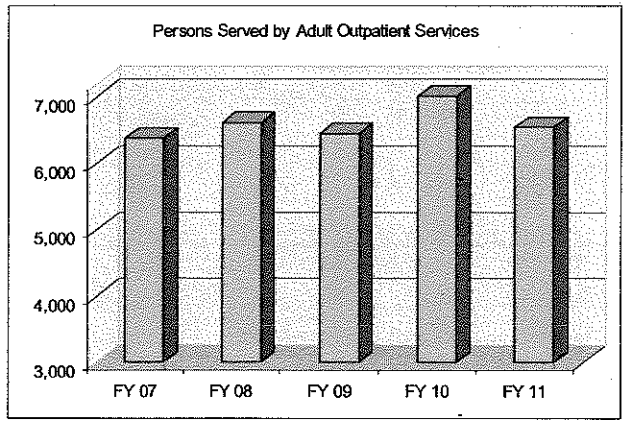
Fiscal Year	Total VSH Patient Days	CRT Patient Days as a % of Total Patient Days
2011	16,849	71%
2010	16,995	63%
2009	17,059	57%
2008	16,618	52%
2007	20,047	54%

Adult Outpatient

The Adult Outpatient Program (AOP) provides services that vary from agency to agency, and delays in access have been identified as a frequent concern. Intake coordinators at each site work with individuals to triage resources to the most urgent needs. Services may include evaluation, individual, family and/or group counseling, medication prescription and monitoring. According to needs assessments and research on prevalence estimates of mental illness, the funding for adult outpatient programs in the designated agency system of care does not support the access to needs of all Vermonters who may need access to assessment or treatment, and should be considered to be part of a larger public and private need for better access to care for primary mental health needs.

An additional challenge to the capacity of the AOP's is the priority population of individuals with severe functional impairments who are eligible for release from the Department of Corrections. These individuals often have complex needs that require significant investments in resources and staff time, further competing with the availability of services to the general public. People in AOP's have a wide range of problems including having attempted suicide within the past year, or having thoughts they may do so. Alcohol and drug abuse is often an additional challenge to many persons in AOP services. Many also have histories of psychological trauma, with lingering impairments to their ability to cope with everyday living, or disabling depression which may pose challenges with such basic activities as eating, bathing, and dressing daily. Other common difficulties include maintaining a household, parenting, managing money, accessing community supports, and needing access to medication prescribing and supports.

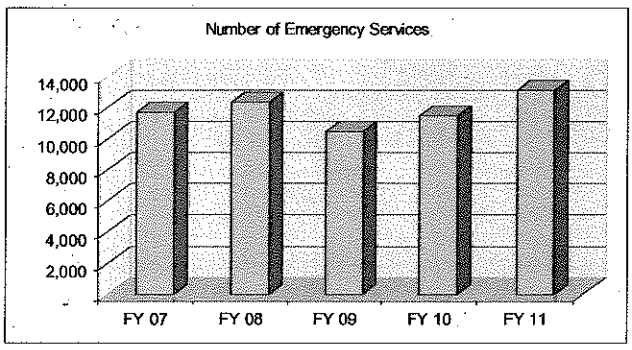
DMH engaged in an active service re-design process with DA providers and key stakeholders during FY 11 to implement alternative services for adults who are not meeting existing service or program criteria, but still had community mental health and support service needs. A number of recommendations emerged from this work, but resources were not available to implement all changes. Expansion of case management services to adults with traditional Medicaid benefits was added and has been available to those who are categorically eligible for service.



Emergency Services

The program provides mental health emergency services twenty-four hours a day, seven days a week to individuals, organizations, and communities. Essential emergency services include telephone support, face-to-face assessment, referral, and consultation. By definition, emergency services respond quickly to avoid poor outcomes so that average response time is within 5 minutes by phone and within 30 minutes when face-to-face assessment is needed. The primary purpose of these crisis programs is to assess the immediate mental health situation and arrange for care as necessary.

Emergency Services Programs provide assistance to people who are in need of crisis services for emergent issues such as depression, suicidal thoughts, dangerous behaviors, family violence and symptoms of serious mental illness. Emergency Services Programs also serve communities, schools, or other organizations trying to cope with events such as suicide, natural disaster and other traumatic events.



Mental Health Transformation Grant

DMH continues to implement a federal *Mental Health Transformation Grant* through the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. This grant will provide funding over five years to foster adoption and implementation of permanent transformative changes in how public mental health services are organized, managed and delivered so that they are consumer- driven, recovery-oriented and supported through evidence-based and best practices.

Under this grant, DMH will expand services for young adults (ages 18-34) with or at risk of serious mental illness who are not currently accessing Community Rehabilitation and Treatment services at their local designated community mental health agency. This population often "falls through the cracks" of our services systems because they are not eligible for CRT services and/or they choose not to access community mental health services. In some cases, these individuals have multiple interactions with law enforcement, homeless shelters, corrections, and hospital emergency rooms.

This initiative will create an effective early intervention system that delivers peer-based, evidence based interventions for this population. In partnership with consumer, family and professional stakeholders, the state will pilot the use of peer services to engage with this population and provide wellness-promotion, recovery self-management and supported employment. Peers will also assist this population with accessing other services and supports in their community (e.g. psychiatric treatment, supported housing, economic services).

The grant will work with existing Adult Local Interagency Teams to create community steering committees for grant activities. These committees will include relevant community partners who may be interacting with this population and support collaboration between local peer service providers and other community partners to improve access to services. As peers engage with this population and achieve positive outcomes, the "lessons learned" from that process will be used by the local programs provide welcoming and accessible services to this population. The grant will also develop a state advisory team to focus on the identification of state-level barriers to treatment and support of this population and strategies to address those barriers.

CHILD, ADOLESCENT, AND FAMILY SERVICES

The Child, Adolescent, and Family Unit (CAFU) oversees a system that provides evidenced-based mental health services and supports to families so that children can live, learn, and grow up healthy in their family, school, and community. CAFU works closely with its network of DAs and one SSA to provide services that include prevention and early intervention, family supports, treatment, immediate response, acute care, and intensive residential placement.

In FY2011, Vermont's public mental health system served over 10,051 youth. As part of its on-going efforts to more effectively and efficiently support Vermont's families as they work to raise healthy children, the CAFU is pursuing the following six significant initiatives.

1. Trauma

Research has now demonstrated that experiencing severe and/or complex trauma alters the way the human brain processes information. In order to assure that young Vermonters in this situation receive effective treatment and support, CAFU applied for and was awarded a Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services grant for just under $400,000 annually for up to 3 years. This award enables DMH to:

- join a new national network of grantees—the *National Child Traumatic Stress Network.*
- establish the *Vermont Child Trauma Collaborative* to implement and sustain the *Attachment, Self-Regulation and Competency (ARC) Framework* in Vermont's community mental health system.
- consult with The Trauma Center at the Justice Resource Institute in Massachusetts for the statewide dissemination of ARC

2. Youth Adults in Transition

Moving beyond the life of a high school student living at home or in a foster home in state custody to the life of an independent adult presents significant and complex challenges to all adolescents. To those adolescents who also experience mental health issues, the challenges are even more difficult to meet. DMH applied for and was awarded a $9 million, 6-year, competitive grant to help take the next steps. For this population, the necessary supports include access to health care, post-secondary education, employment, housing, and caring relationships with adults who nurture positive youth development. Three strategies used by all 12 regions include the following.

- Young adults will be empowered throughout the state to help design a young adult driven system of care.
- All agencies/departments serving young adults aged 16 – 23 will work together to create a young adult driven system of care.
- Mental health and substance abuse services will be designed for this young adult driven system of care.

3. Youth Suicide Prevention

While most youth in crisis don't attempt it, suicide remains the second leading cause of death for Vermont youth between the ages of 11 and 23. In most cases it is preventable – if adults know the warning signs and the steps they can take to get help for a young person. Working in collaboration with the Center for Health and Learning, CAFU was awarded a $1.5 million grant from the SAMHSA. It has achieved its objectives including the following.

- Develop a public education program about mental health entitled *UMatter.* It is aimed at individuals and service professionals and based on the concept that it is important to get and to give help when people are in emotional pain.
- Administer the evidenced-based Gatekeeper Program's *Lifelines* curriculum in selected schools.

- Establish protocols using the *Connect* curriculum for first responders, faith-based organizations, and primary care providers in selected communities. At this time, the grant's coalition has trained:
  - all staff for 2-1-1 in the Life Lines curriculum;
  - more than 552 service professionals and 6 media outlets; and
  - 22 trainers capable of training other professionals on prevention and postvention work.

4. Family Mental Health Model

The DMH, the Vermont Children's Health Improvement Project (VCHIP), and the Department of Child Psychiatry at the University of Vermont (UVM) have been collaborating for 6 years to develop a collaborative vision of family mental health. This vision includes the following elements.

- Child Psychiatric Fellowship Program at UVM to train and retain child psychiatrists.
- A Family Mental Health Program that includes evidenced-based practices to provide mental health wellness, prevention, and treatment services.
- The Family Mental Health model is being discussed with the developers of the Vermont Blueprint for Health for use with pediatric practices.
- Co-location of mental health professionals in primary care offices.
- UVM Child Psychiatric Fellow worked with DMH's child psychopharmacology workgroup on academic detailing.

5. Integrated Family Services (IFS)

AHS children's services fall in 6 departments and multiple divisions of the agency. Divisions and departments historically developed separate and distinct Medicaid waivers and Medicaid procedures for serving specialty populations. The Integrated Family Services Initiative seeks to bring all agency child, youth, and family services together in an integrated and consistent continuum of services for families. The premise is that giving families early support, education, and interventions will produce more favorable outcomes at a lower cost than the current practice of *waiting until circumstances are bad enough* to access *high end funding* streams which often result in out of home or out of state placement.

AHS will integrate human services to create a continuum of services from which families may choose and base service delivery on the specific diagnostic and functional needs of each child, youth, and family. Service options will be guided by best practices in clinical service, early, intervention, and family support. The system will monitor outcomes and integrate AHS funding across programs in order to meet these goals effectively.

6. Success Beyond Six (SBS):

Vermont has been actively developing its partnerships between mental health, education, and students and their families under the Success Beyond Six (SBS) partnership since its official start in December 1992. In Success Beyond Six, school districts or supervisory unions contract with their region's community mental health center. Together they hire and supervise staff using 30% general funds from education to draw down 70% federal Medicaid funds through mental health. In FY2011, they hired 592 full time equivalent (FTE) staff to provide needed services to 3,742 students, primarily those eligible for Medicaid. The total program's budgeted expenditures were $46,294,687.

SBS now operates from a basic state-wide contract template with detailed local work requirements, provides state-wide training and skills guidelines for the position of Behavioral Interventionist, collects data on children served, and works to support the Department of Education's efforts to implement Positive Behavioral Interventions and Supports (PBIS, also known as PBS), an education evidence-based practice.

VERMONT STATE HOSPITAL & INPATIENT HOSPITALIZATION

The Department of Mental Health, pursuant to 18 V.S.A. § 7205 operated the Vermont State Hospital (VSH) until August 29, 2011. Tropical Storm Irene forced the evacuation of the 52 individuals hospitalized at VSH. Subsequent to closure, former patients of VSH were discharged, moved to hospitals, recovery residences or crisis bed programs, and secure facilities throughout Vermont. The Commissioner of the Department of Mental Health remains statutorily responsible for the supervision of patients receiving involuntary mental health treatment at the five designated hospitals throughout the state:

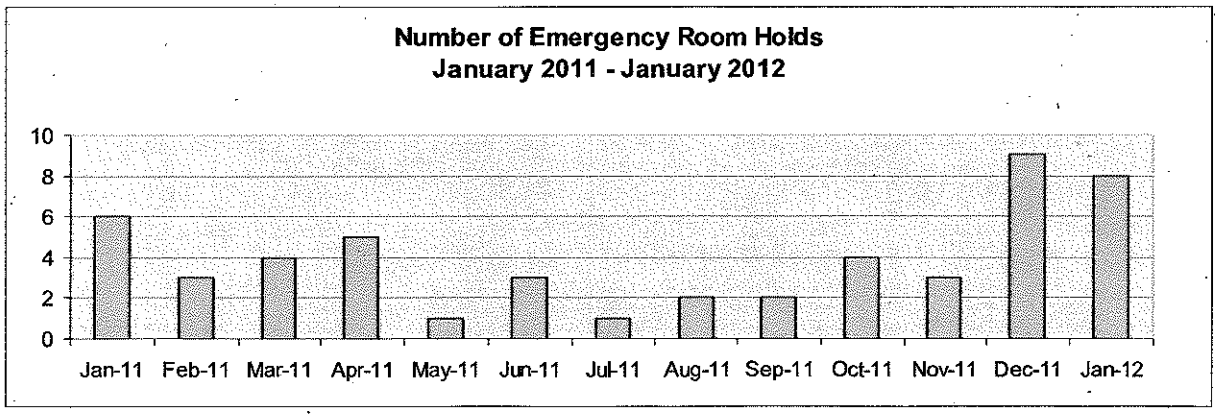
- Fletcher-Allen Health Care
- Central Vermont Medical Center
- Rutland Regional Medical Center
- Windham Center
- Brattleboro Retreat

These responsibilities include persons undergoing emergency examinations, court-ordered or forensic evaluations, and ongoing treatment for individuals whose mental health needs are beyond the community's capacities.

At the present time, former VSH personnel are deployed primarily to psychiatric units of hospitals and the Second Spring Recovery Residence providing a variety of consultative and direct hands-on services side-by-side with employed personnel of those facilities. In the upcoming month, as these inpatient and residential programs develop their staffing and treatment capabilities, it is anticipated that these facilities will no longer require the services of state personnel. At that time, only a handful of individuals, who require safe and secure surroundings that have not been replicated in the community, will require the direct services of a state workforce. Planning pertaining to staffing models and assumptions for the care environment are currently in process.

DMH is also actively working with the State's Human Resources Department to prepare for and management successful transitions for the VSH workforce. Options for re-deployment or hiring in other Agency of Human Services Departments, job fairs and resume support services, and retirement planning are all under consideration.

At the present time and throughout FY 13, DMH will be aggressively pursuing interim hospital options to meet the needs of persons requiring inpatient care and the development and construction plans for building a new, state managed hospital to replace the facility lost on August 29, 2011. Emergency Room holds tracked over the past twelve months shows the number of persons proposed for emergency examination admissions significantly increased in December 2011 and January 2012 as acute care inpatient bed capacity remains constrained.



The Department of Mental Health

State Strategic Plan: 2011 – 2013

DRAFT

Department of Mental Health
Agency of Human Services
26 Terrace Street
Montpelier, VT 05609
802-828-3824
www.mentalhealth.vermont.gov

Purpose

This document provides an overview of the Department of Mental Health's (DMH) vision for the future of mental health services in Vermont over the next three years and establishes key priority goals and objectives to be completed in the next 12 months to support that vision. This plan is not meant to be static; the goals and objectives in this document will continue to be updated and modified based on the changing landscape of mental health, input we receive from stakeholders as we implement our action steps, and specific data that we collect to evaluate the effectiveness of our implementation. Information about this strategic plan and the progress of implementation will be available on DMH's website at www.mentalhealth.vermont.gov.

Sources of Input and Information

In preparation for the creation of this strategic plan, the Department of Mental Health has been working with local, state and federal stakeholders to identify:

- Unmet needs for Vermonters with mental health needs;
- Strengths and areas of improvement for our current mental health system;
- Opportunities to expand and improve mental health services in Vermont;
- Current and future threats that may impair our ability to support individuals and families with mental health needs;
- Innovative and evidence-based approaches and models to providing and supporting mental health services.

Input and information have come from a variety of sources:

- Local and state standing committees;
- Mental Health Transformation Council;
- Designated Agency (DA) Executive Directors and Program Directors for DA Outpatient, Children's, Emergency, and Community Rehabilitation and Treatment Programs;
- Local and State System of Care Plans;
- Other Agency of Human Services Departments;
- State Legislation (e.g. Act 15 – An act creating the Department of Mental Health);
- Federal Legislation (e.g. the Affordable Care Act);
- Federal Directives and Planning Documents (e.g. SAMHSA's new strategic priorities, new Mental Health Block Grant requirements);
- Public input via the DMH Strategic Planning Website;
- DMH staff.

Guiding Principles

The development and implementation of this strategic plan will be guided by the following principles:

- DMH will include consumers, peers, families, providers, and community and state partners in the planning, development and provision of the activities, services and supports referenced in this plan.
- DMH will collect and use reliable data to demonstrate the achievement of our strategic goals.
- DMH will continue to support mental health care that is:
  - ***Person and family-centered***
  - Focused on ***recovery and resiliency***
  - Supportive of ***individual choice and self-determination***
  - Based on ***evidence*** of improved individual and family ***outcomes.***

The Public Health Model for Mental Health

DMH's vision for the future of mental health services in Vermont will also incorporate the "Public Health Model" as it applies to mental health. As described in the 2010 monograph *A Public Health Approach to Children's Mental Health: A Conceptual Framework,* there are four key concepts of this model that can be applied to mental health:

Population Focus: Public health thinks about, intervenes with, and measures the health of the entire population and uses public policy as a central tool for intervention.
Promoting and Preventing: In public health, the focus includes preventing problems before they occur by addressing sources of those problems, as well as identifying and promoting conditions that support optimal health.
Determinants of Health: Interventions in public health work by addressing determinants of health. Determinants are factors that contribute to the good and bad health of a population. Malleable factors that are part of the social, economic, physical, or geographical environment can be influenced by policies and programs.
Process/Action Steps: A public health approach requires implementation of a series of action steps. In most widely recognized health models, these action steps are the three core functions of assessment, policy development, and assurance. Data are gathered to drive decisions about creating or adapting policies that support the health of the population, and efforts are made to make sure those policies are effective and enforced.

This monograph also lays out four categories of interventions based on the type of action, the timing of the intervention, and the population goal:

	Action	*Timing*	*Population Goal*
Promote …is to intervene…	to *optimize* positive mental health by addressing determinants of positive mental health	***before* a specific mental health problem has been identified in the individual, group, or population of focus**	**with the ultimate goal of improving the positive mental health of the population.**

Prevent …is to intervene…	to *reduce* mental health problems by addressing determinants of mental health problems	***before* a specific mental health problem has been identified in the individual, group, or population of focus.**	**with the ultimate goal of reducing the number of future mental health problems in the population.**
Treat …is to intervene…	to *diminish* or end the effects of an identified mental health problem	*after* a specific mental health problem has been identified in the individual, group, or population of focus	**with the ultimate goal of approaching as close to a problem-free state as possible in the population of focus.**
Re/Claim …is to intervene…	to *optimize* positive mental health while taking into consideration an identified mental health problem.	*after* a specific mental health problem has been identified in the individual, group, or population of focus	**with the ultimate goal of improving the positive mental health of the population of focus.**

This model will serve as the framework for the Department of Mental Health as it identifies and implements our strategic priorities to improve the mental health of all Vermonters.

Vision, Priority Goals and Objectives

Using our guiding principles and the public health model as our framework, the Department of Mental Health has established the following vision and priority goals and objectives to achieve our vision:

VISION

Mental health will be a cornerstone of health in Vermont. People will live in caring communities with compassion for and a determination to respond effectively and respectfully to the mental-health needs of all citizens. Vermonters will have access to effective prevention, early intervention, and mental-health treatment and supports as needed to live, work, learn, and participate fully in their communities.

PRIORITY GOALS: 2011 - 2013

Over the next three years, DMH will implement strategies that:

- ☐ Promote mental health and wellness for all Vermonters (Promotion),
- ☐ Protect all Vermonters from the risks for mental disorders (Prevention),
- ☐ Intervene early to treat mental health problems (Early Intervention);
- ☐ Provide support and treatment to achieve recovery and resiliency (Re/claiming Mental Health).

Through the implementation of these goals, DMH will strive to use and increase the availability and quality of person and family-centered, evidence-based interventions focused on achieving specific individual, family, and population-based outcomes.

OBJECTIVES TO BE COMPLETED OVER NEXT 12 MONTHS

To achieve the goals described above, DMH has established the following objectives to be completed over the next 12 months:

1) DMH will work with the Vermont Department of Health to establish core mental health promotional messages to be shared in schools and primary care offices by July 2012. (Promotion)

2) DMH will develop and disseminate a state-wide Mental Health Prevention Plan by October 2012. (Prevention)

3) DMH will restructure the funding mechanisms for school-based mental health clinicians to increase flexibility and increase the use of mental health promotion and prevention (e.g. Positive Behavioral Interventions and Supports) within schools by January 2012. (Promotion, Prevention)

4) DMH will establish two demonstration sites to provide peer-based prevention and early intervention services for young adults with or at risk of serious mental illness by February 2012. (Prevention, Early Intervention)

5) DMH will continue to support the development and implementation of Integrated Family Services. (Prevention, Early Intervention, Reclaiming Mental Health)

6) DMH will work with the Blueprint for Health to identify and support screening and focused intervention for people presenting with depression in the primary care offices by the fall of 2013. (Early Intervention)

7) DMH will work with the Blueprint for Health to establish core guidelines for the provision of psychiatric consultation for Blueprint primary care practices by August 2012. (Early Intervention)

8) DMH will work with the Blueprint for Health to establish a pediatric mental health services model for mental health by July 2012. (Early Intervention)

9) DMH will finalize plans to replace the Vermont State Hospital with a state-of-the-art facility, core hospital diversion and step-down facilities, and additional enhanced community supports by October 2012. (Reclaiming Mental Health)

10) DMH will complete state-wide implementation of the evidence-based Attachment, Self-Regulation and Competency (ARC) Framework for treatment of children with complex trauma and their families by October 2012. (Reclaiming Mental Health)

11) DMH will support the development of an Evidence Based Practice Cooperative to support the implementation of evidence-based and recovery-oriented practices for adults with severe and persistent mental illness by August of 2012. (Reclaiming Mental Health)

12) DMH will partner with AHS to establish shared vision, approach and expectations (e.g. MOU's, policies, protocols, shared workforce development) for coordinated re-entry services for adults with severe functional impairment by the fall 2012. (Reclaiming Mental Health)

DMH Dashboard Indicators: Measures of System Improvement

As part of the strategic planning process, DMH will be working to identify "Dashboard Indicators[1]" to measure improvements in the mental health system. DMH has already identified one indicator to show that our system is helping individuals to reclaim mental health (employment rates for clients of Community Rehabilitation and Treatment), and we will be adopting the Integrated Family Services indicators (under development) for children and families in Vermont. Other indicators focused on promotion, prevention and early intervention will also be established.

DMH Objectives and the State of Vermont Priorities for 2011

The DMH Objectives described above have been aligned with the ***State of Vermont Priorities for 2011 (in development)*** and will significantly contribute to the following priorities:

- **The Economy:** Create a brighter economic future for Vermonters by raising incomes, growing jobs and improving job preparedness.

- **Correctional Recidivism:** Implement a sustained interdepartmental approach to reduce recidivism and the overall need for corrections resources.

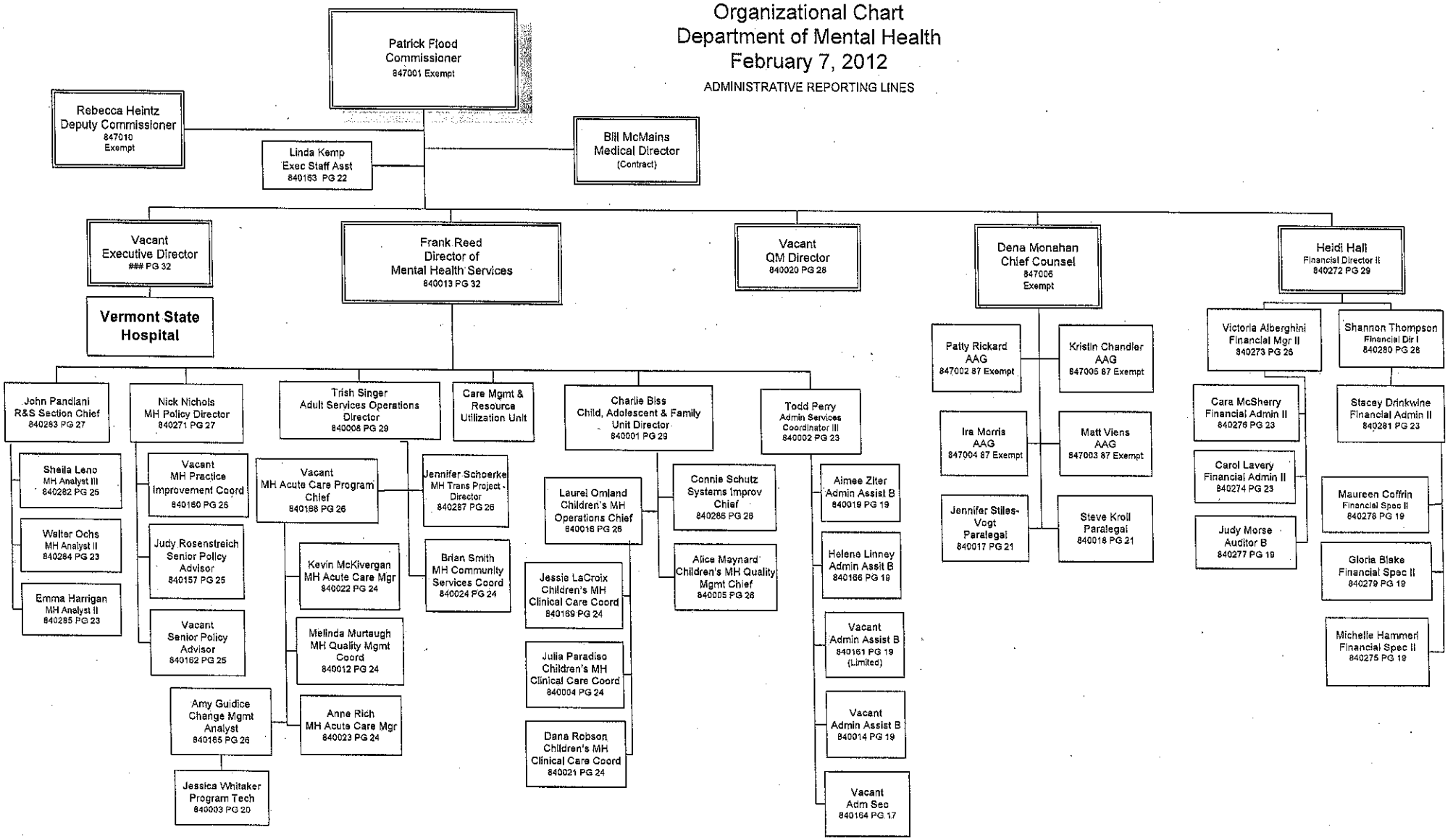
-**Affordable Health Care:** Support Vermonters in the maintenance of their health through prevention and through affordable quality health care for all in a manner that supports small employers and overall economic growth, and that results in better care.

-**Safe Communities/Strong Schools:** Prioritize our resources to ensure our children's future in safe, prosperous communities, thereby supporting improvement in the performance and economic sustainability of our schools.

[1] Dashboard Indicators are "like a scorecard- allowing users to review performance and outcomes information (employment, housing, staying out of crisis centers, abstaining from substance abuse, avoiding arrests, etc.) at the statewide level, as well as by region of the state and separately for adults and children." (http://directorsblog.health.azdhs.gov/?p=1675)

Organizational Chart
Department of Mental Health
February 7, 2012

ADMINISTRATIVE REPORTING LINES



DEPARTMENT OF MENTAL HEALTH
FY13 BUDGET REQUEST
February 16, 2012

Staffing, Operating and Internal Service Fund Items, MH:
Regular Salary and Fringe changes due to regular turnover and rate changes, insurances, and internal fund adjustments.

-Changes in Salary and Fringe:	
$89,161 Gross	$ 40,002 GF
-Fee For Space:	
$92,400 Gross	$ 39,956 GF
-VISION:	
$ 39,091 Gross	$ 16,904 GF
-Dept of Human Resources:	
$49,124 Gross	$ 21,242GF
-General Liability:	
($2,780) Gross	($1,202) GF
-All other Insurances:	
$ 183 Gross	$ 79 GF
-DII:	
($ 27,417) Gross	($ 11,856) GF

DMH Care Management, Utilization, and Quality Assurance Services:
$ 1,473,684 Gross $ 654,510 GF
DMH will be reallocating 23 positions from the VSH to provide care management and ensure system integrity and effectiveness.

DMH Psychiatric Services for the Care Management System:
$ 458,355 Gross $ 205,402 GF
DMH will reallocate two contracted Psychiatrist from the VSH to provide professional expertise to the Care Management, Utilization, and Quality Assurance programs.

Agency of Human Services Community Initiatives (C4C):
$ 918,048 GC $ 399,994 GF
Global Commitment Community Pilots targeting reduced length of stay in hospital for children and adults, diversion of unnecessary hospitalization or avoidable Emergency Room visits for both groups, and decreased incarceration days for adults.

Severely Functionally Impaired supports:
$ 200,000 GC $ 87,140 GF
Individualized support service plans to reduce incarceration bed days and decrease recidivism for individuals returning to the community from DOC.

Social Services Block Grant Reduction:
($7,264) Fed $7,264 GF
The current MH allocation of the Social Services block grant is $433k. Funding is used to support CRT services. This reduction in federal funds will be replaced with state funds.

Community Health Center (AHS net neutral):
$21,500 GC $9,368 GF
This is a transfer of the DVHA funds allocated to the Community Health Center in Burlington to provide healthcare services to the homeless. This brings the total MH grant to $200k.

Jump On Board for Success (JOBS) (AHS net neutral):
$30,832 GC $13,434 GF
The JOBS programs provide employment services and intensive case management services for youth with severe emotional/behavioral disabilities in 14 sites statewide. Youth served by the program are at high risk for involvement with corrections, drug and alcohol abuse and other negative outcomes.

Therapeutic Foster Care (AHS net neutral):
$350,000 GC $152,495 GF
Northeastern Family Institute went to a bundled rate funding model in FY 12. This moves the therapeutic foster care room and board from DCF to be included in the bundled rate.

Success Beyond Six (Locally matched):
$1,000,000 GC $435,700 GF
Overall program growth for the SBS program, which includes behavioral interventionists, school-based clinicians, and funding for specialized schools, is anticipated to be approximately $1M more than the fy12 base appropriation, bringing the program total to $37.5M. Match is paid for by the local schools.

HCRS Sparrow Project:
$130,517 GC $56,866 GF
The HCRS Justice Reinvestment Project of Windsor County (aka the Sparrow Project) provides screening, assessment, intensive case management and service coordination to individuals with substance abuse, mental health, co-occurring, developmental disability issues and other serious functional impairments.

Expansion of Adult Community Services:
$8,000,000 GC $3,485,600 GF
Funding will be used to improve existing community to include improved emergency response, mobile support teams, noncategorical case management, adult outpatient services, and alternative residential opportunities at designated agencies.

Brattleboro Retreat, 14 beds:
$8.068.600 GC $3,515,489 GF
Acute psychiatric inpatient hospitalization replacement capacity for VSH

Crisis Beds, 2 2-bed programs:
$1.000.000 GC $ 435,700 GF
Cost-effective crisis stabilization supports to divert hospitalization and/or step-down to community services from hospitalization and anticipated to be less than 30 days. This will bring the system crisis bed capacity to 31.

Intensive Outreach program:
$315,000 GC $137,246 GF
Stabilization and Recovery Team (START) operated by HCHS. This multidisciplinary team will include a case manager, support clinicians, a nurse, and a psychiatrist. Peers will be recruited for inclusion in this model.

Peer Support Programs:
$1,000,000 GC $435,700 GF
Funding will support new peer services and to expand existing programs managed by peers that provide support to individuals living with or recovering from mental illness.

Hilltop – VSACC collaboration, 8 beds:
$2,435,506 GC $1,061,150 GF
Staff secure intensive residential recovery/ one bed ER overflow.

5 bed Peer run program:
$300,000 GC $ 130,710 GF
Consumer-directed and peer run alternative support program as an alternative to traditional "medical model" psychiatric stabilization. This program may allow diversion of some psychiatric hospitalizations and serve to step-down individuals from inpatient psychiatric care.

Pathways to Housing, 20 supported units:
$373,000 GC $ 162,516 GF
Community support team services using a "Housing First" treatment model to offer structured, daily assertive treatment and support service to persons; and securing stable housing as a core treatment component.

Housing Vouchers:
$600,000 Gross $ 600,000 GF
Funds will be used to provide housing subsidies to individuals living with or recovering from mental illness for the purpose of fostering stable and appropriate living conditions. Receipt of housing subsidies shall not require an agreement to accept certain services as a condition of assistance.

Additional Transitional Residential Facilities (sites TBD):
$3,200,000 GC $1,394,240 GF
Funding for up to 23 additional intensive residential recovery beds.

Acute Inpatient Facilities, 15-20 beds:
$13,000,000 GC $5,664,100 GF
Acute, psychiatric hospital level of care facility to provide inpatient evaluation, stabilization, and treatment services.

VSH – Waterbury Location:
($20,373,862) Gross ($16,625,003) GF
Closing of the Waterbury based Vermont State Hospital due to the losses incurred by Hurricane Irene.

	GF	SF	IdptT	FF	Medicaid GCF	Invmnt GCF	TOTAL
DMH Mental Health - As Passed FY12	**811,295**	**6,836**	**20,000**	**6,555,971**	**114,648,966**	**8,930,505**	**130,973,573**
Adjustments:							**0**
Retirement rate reduction GF savings	**(1,644)**						**(1,644)**
Benefit rate reductions	**(622)**						**(622)**
							0
							0
							0
							0
Total Adjustments	**(2,266)**	**0**	**0**	**0**	**0**	**0**	**(2,266)**
Total After FY12 Adjustments	**809,029**	**6,836**	**20,000**	**6,555,971**	**114,648,966**	**8,930,505**	**130,971,307**
FY12 After Adjustments							
Personal Services:							
SFY '12 Retirement rate reduction--non-GF component					(3,706)		**(3,706)**
Increase in DMH Capacity - (utilize VSH staff) (net neutral)	119,501			126,254	1,124,275	103,654	**1,473,684**
Psychiatric srv for Care Management System	35,293			32,635	360,955	29,472	**458,355**
							0
Salary	4,713			4,357	29,837	22,297	**61,204**
FICA	361			334	2,285	1,707	**4,687**
Life	(3)			(3)	(21)	(16)	**(43)**
LTD	(3)			(3)	(21)	(16)	**(43)**
Retire	(1,407)			(1,301)	(8,908)	(6,657)	**(18,273)**
EAP	6			6	42	31	**85**
Health	538			498	3,408	2,547	**6,991**
Dental	283			262	1,794	1,341	**3,680**
FY 13 Retire Increase	2,135			1,974	13,517	10,101	**27,727**
Workers Comp Increase	528			488	3,340	2,496	**6,852**
Operating Expenses:							
FFS/ Lease change due to relocation	(1,368)			(2,467)	(50,690)	(37,875)	**(92,400)**
VISION	579			1,044	21,445	16,023	**39,091**
DHR	727			1,312	26,949	20,136	**49,124**
General Liability	(41)			(74)	(1,525)	(1,140)	**(2,780)**
All Other Insurance	3			5	100	75	**183**
DII	(406)			(732)	(15,041)	(11,238)	**(27,417)**

	GF	SF	IdptT	FF	Medicaid GCF	Invmnt GCF	TOTAL
Grants:							**0**
Community Initiatives (C4C)						918,048	**918,048**
Severely Functionally Impaired (SFI) initiative					100,000	100,000	**200,000**
Social Services Block Grant reduction	7,264			(7,264)			**0**
Community Health Center xfer from DVHA (AHS net neutal)						21,500	**21,500**
JOBS - Additional DOC commitment (AHS net neutral)					30,832		**30,832**
Therapeutic Foster Care xfer from DCF (AHS net neutral)					350,000		**350,000**
SBS Utilization Increase					1,000,000		**1,000,000**
HCRS Sparrow Project						130,517	**130,517**
							0
Emergency Services expansion					3,000,000		**3,000,000**
Brattleboro Retreat 15-20 beds					8,068,600		**8,068,600**
Additional Crisis Beds					1,000,000		**1,000,000**
Intensive Outreach program						315,000	**315,000**
Peer Supports expansion					1,000,000		**1,000,000**
Individual Services					5,000,000		**5,000,000**
Hilltop, VSACC collab - 7 beds					2,435,506		**2,435,506**
5 bed Peer run program						300,000	**300,000**
Pathways - 20 supported housing units						373,000	**373,000**
Housing Vouchers	600,000						**600,000**
Transitional Residential Facility					3,200,000		**3,200,000**
Acute Inpatient Psychiatric Facilities					13,000,000		**13,000,000**
FY13 Changes	**768,703**	**0**	**0**	**157,325**	**39,692,973**	**2,311,003**	**42,930,004**
FY13 Gov Recommended	**1,577,732**	**6,836**	**20,000**	**6,713,296**	**154,341,939**	**11,241,508**	**173,901,311**
FY13 Legislative Changes							**0**
FY13 As Passed - Dept ID 3150070000	**1,577,732**	**6,836**	**20,000**	**6,713,296**	**154,341,939**	**11,241,508**	**173,901,311**

	GF	SF	IdptT	FF	Medicaid GCF	Invmnt GCF	TOTAL
DMH - Vermont State Hospital - As Passed FY12	**17,016,067**	**835,486**	**300,000**	**213,564**	**4,252,718**		**22,617,835**
Adjustments:							**0**
Retirement rate reduction GF savings	**(104,210)**						**(104,210)**
Benefit rate reductions	**(139,763)**						**(139,763)**
AHS portion of $12M statewide savings initiative	**(2,000,000)**						**(2,000,000)**
							0
Total Adjustments	**(2,243,973)**	**0**	**0**	**0**	**0**	**0**	**(2,243,973)**
Total After FY12 Adjustments	**14,772,094**	**835,486**	**300,000**	**213,564**	**4,252,718**	**0**	**20,373,862**
FY12 After Adjustments							
Personal Services:							
VSH closing	(13,918,201)	(835,486)	(300,000)	(213,564)	(2,928,897)		**(18,196,148)**
Movement of 18.5 FTEs to Mental Health approp. (net neutral)					(1,473,684)		**(1,473,684)**
Net-neutral position transfer to DAIL	(60,000)						**(60,000)**
Workers Comp Increase					185,876		**185,876**
Operating Expenses:							
General Liability					(38,793)		**(38,793)**
All Other Insurance					2,780		**2,780**
Fee for Space	(793,893)						**(793,893)**
FY13 Changes	**(14,772,094)**	**(835,486)**	**(300,000)**	**(213,564)**	**(4,252,718)**	**0**	**(20,373,862)**
FY13 Gov Recommended	**0**	**0**	**0**	**0**	**0**	**0**	**0**
FY13 Legislative Changes							**0**
FY13 As Passed - Dept ID 3150080000	**0**	**0**	**0**	**0**	**0**	**0**	**0**

TOTAL FY12 DMH Big Bill As Passed	**17,827,362**	**842,322**	**320,000**	**6,769,535**	**118,901,684**	**8,930,505**	**153,591,408**
TOTAL FY12 DMH Adjustments	**(2,246,239)**	**0**	**0**	**0**	**0**	**0**	**(2,246,239)**
TOTAL FY13 DMH Starting Point	**15,581,123**	**842,322**	**320,000**	**6,769,535**	**118,901,684**	**8,930,505**	**151,345,169**
TOTAL FY13 DMH ups & downs	**(14,003,391)**	**(835,486)**	**(300,000)**	**(56,239)**	**35,440,255**	**2,311,003**	**22,556,142**
TOTAL FY13 DMH Gov Recommended	**1,577,732**	**6,836**	**20,000**	**6,713,296**	**154,341,939**	**11,241,508**	**173,901,311**
TOTAL FY13 DMH Legislative Changes	**0**	**0**	**0**	**0**	**0**	**0**	**0**
TOTAL FY13 DMH As Passed	**1,577,732**	**6,836**	**20,000**	**6,713,296**	**154,341,939**	**11,241,508**	**173,901,311**